License Verification

Data As Of **2/28/2012**

MICHAEL J BENJAMIN

LICENSE NUMBER: **ME14909**

Profession

MEDICAL DOCTOR

License/Activity Status

CLEAR/ACTIVE

Qualifications

Dispensing Practitioner

License Expiration Date

1/31/2014

License Original Issue Date

12/31/1973

Discipline on File

YES

Public Complaint

YES

Address of Record

7777 N. UNIVERSITY DR
SUITE 102
TAMARAC, FL 33321

The information on this page is a secure, primary source for license verification provided by The Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Active Medical Doctor License # ME 14909 expires January 31, 2006.

The fee of **$454.00** and the renewal notice must be postmarked on or before January 31, 2006. Renewal notices postmarked on or after February 1, 2006 require renewal and delinquent fees of **$839.00.**

DEPARTMENT USE ONLY

This address will be used for all correspondence from the Department of Health.

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

This address will be printed on your license and posted on the Internet.

7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

Go to **www.doh-mqaservices.com** to renew your license, change your address, and confirm information maintained by the Department. Listed below is your Account ID and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

Avoiding complaints can protect your clients and your ability to practice. Go to **www.doh.state.fl.us/mqa/avoid.html** to find out more.

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license, please provide the updated information in the appropriate fields of section 7 on the back of this form.

A. Online Renewal: Visit **www.doh-mqaservices.com** go to the Practitioner Logon box, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2006. To use the online system, you will need the following information:

Account ID:
Password

(Note: Account ID and Password must be entered exactly as they appear.)

The online renewal system will allow practitioners to update their mailing address and to confirm licensee information maintained by the Department. Practitioners will receive confirmation of their successful renewal before logging out of the system.

B. **U.S. Mail:** Mail completed form and fee payable to the Department of Health to the following address:
Department of Health, Division of Medical Quality Assurance, PO Box 6320, Tallahassee, FL 32314-6320

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 10330 Sequence Number: 2721
Profession Code: 1501 20 20

Please make changes to your license information in section 7 on the BACK of this form.

Florida Department of Health - Board of Medicine

License Renewal Notice

Active (group 1) Medical Doctor License # ME 14909 expires January 31, 2002.

To avoid a delinquent charge, the fee of **$406.00** and the renewal form must be postmarked or electronically submitted on or before January 31, 2002. Renewal notices/forms postmarked on or after February 1, 2002 require renewal and delinquency fees of **$791.00.**

1. CHANGE OF MAILING ADDRESS:

Current Mailing Address:

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

New Mailing Address:

Licensee's Last Name: First: Middle Initial:
Attn:
Street Address:
City: State: Zip:
Phone: ( )

DEPARTMENT USE ONLY

-200

Received Date : 11/23/01
[illegible] Date : 12/3/01
Deposit # : 167417
Batch Number : 008356
Validation # : 901070691
Check Amount : $406.00
PROCODE : 1501

2. CHANGE OF PRACTICE LOCATION:

Current Practice Location:

7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

New Practice Location:

Attn:
Street Address:
City: State: Zip:
Phone: ( )

3. Chapter 456, F.S. requires a background check to renew a license, please review the following data to verify that the information is correct, please make any necessary corrections. This information is critical in ensuring that all background checks are attributed to the correct licensee.

Description	Department Information	Information is Accurate	Correct Information
Social Security #		✓ Yes ○ No	
Date of Birth	05/23/40	✓ Yes ○ No	
Sex	Data Missing	✓ Yes ○ No	male
Race	Not Given	✓ Yes ○ No	white
Race Options: White, Black, Native, Asian, Other, Hispanic & not given			

4. COMPLETE THE FINANCIAL RESPONSIBILITY FORM ON THE REVERSE SIDE OF THIS FORM.

5. MILITARY STATUS:

○ I am requesting Military Restricted Status. (Military Restricted must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.)

○ Please remove the Military Restricted Status from my license. (Provide copy of DD214 or letter from Commanding Officer.)

6. Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergencies declared by the governor?

✓ Yes

7. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Internet E-Renewal: Web address http://www.doh.state.fl.us/erenewal

E-Renewal allows you to make address changes. E-Renewal does not allow you to renew online by adding or removing a status, such as paying a delinquency fee or changing a license status. Due to high volume, allow sufficient time to renew since **e-Renewal will not be available after midnight Eastern Time (ET) January 31, 2002.** E-Renewal will require the following information:

PIN Number
License Number: ME 14909

B. U.S. Mail:

Mail this completed renewal form and fee payable to the Department of Health to:

P.O. Box 6320
Tallahassee, Florida 32314-6320

8. Other Information:

File Number: 10330 20 20 Sequence Number: 3138

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iHEADER                    PRAES Production (MQ-P)                    10/12/99
aguins                                                                15:53:17
øtnrbal12/2.13               MAINTAIN ANY LICENSE DATA            1501/MED-MEø
øFile: 10330                                                                 ø
øSSN:               Medical Doctor                                           ø
øLic:   14909       CLEAR,ACTIVE                                             ø
øName: MICHAEL J BENJAMIN (DBA:0 Old:0)                                      ø
øAddr: 7707 N UNIVERSITY DR  SUITE 205           State:   FL                 ø
ø                                                Zip:     33321              ø
øCity: TAMARAC                                   County:  BROWARD            ø
ø                                                                            ø
øCertificate No: P373622     First License:   12/31/1973                     ø
ø      "    Date: 12/23/1997  In Rank Since:   12/31/1973                    ø
øLast Renewal:               License Method:  EXEN                           ø
øCurrent Expiry: 01/31/2000  Renewal Notice:                                 ø
ø                            In Directory?     Include                       ø
øStatus Date:    01/01/1801  Fee Exempt?      N                              ø
øNote:                                                                       ø
ø                                                                            ø
ø                                                                            ø
øAction:  Query  Transfer  A-Address  B-Basic_Data  C-PSD  D-Contact_Hst ... ø
ø         Go to view only options                                            ø
               1 Sess-1    167.78.1.20                                1 22/9
```

10/14/1999 $43.00
ID: 1501-10330 Type: F
BT: H01282 DP: 168178
VL: 99027713

Florida Department of Health - Board of Medicine
LICENSE RENEWAL NOTICE

Active Medical Doctor License # ME 14909 expires January 31, 2006.

Received Date : 12/2/05
Deposit Date : 12/9/05
Deposit # : 167169
Batch Number : 1011948
Validation # : 905137382
Check Amount : $454.00
PRO_CDE : 1501

The fee of **$454.00** and the renewal notice must be postmarked on or before January 31, 2006. Renewal notices postmarked on or after February 1, 2006 require renewal and delinquent fees of **$839.00.**

1. CURRENT MAILING ADDRESS:
This address will be used for all correspondence from the Department of Health.

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

2. CURRENT PRACTICE LOCATION:
This address will be printed on your license and posted on the Internet.

7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

3. RENEW ON LINE TODAY!

Go to www.doh-mqaservices.com to renew your license, change your address, and confirm information maintained by the Department. Listed below is your Account ID and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

Avoiding complaints can protect your clients and your ability to practice. Go to www.doh.state.fl.us/mqa/avoid.html to find out more.

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license, please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit www.doh-mqaservices.com go to the Practitioner Logon box, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2006. To use the online system, you will need the following information:

Account ID
Password
(Note: Account ID and Password must be entered exactly as they appear.)

The online renewal system will allow practitioners to update their mailing address and to confirm licensee information maintained by the Department. Practitioners will receive confirmation of their successful renewal before logging out of the system.

B. U.S. Mail: Mail completed form and fee payable to the Department of Health to the following address:
Department of Health, Division of Medical Quality Assurance, PO Box 6320, Tallahassee, FL 32314-6320

6. Other Information:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 10330 Sequence Number: 2721
Profession Code: 1501 20 20

Please make changes to your license information in section 7 on the BACK of this form.

MQA

Florida Department of Health - Board of Medicine
LICENSE RENEWAL NOTICE

Active Medical Doctor License # ME 14909 expires January 31, 2004.

Received Date : 12/22/03
Deposit Date : 12/22/03
Deposit # : 167461
Batch Number : 011897
Validation # : 903099180
Check Amount : $454.00
PRO_CDE : 1501

The fee of **$454.00** and the renewal notice must be postmarked on or before January 31, 2004. Renewal notices postmarked on or after February 1, 2004 require renewal and delinquent fees of **$839.00**.

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the Internet.

7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

3. RENEW ON LINE TODAY!

Go to www.doh-mqaservices.com and renew your license, change your address, and update your profile. Listed below is your user id and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, biographic information, license status or military status information associated with your license. Please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit https://www.doh.state.fl.us/mqaservices and click on Renew My License to renew your license online. If you are requesting a status change you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2004. To use the online system, you will need the following information:

Account ID:
Password
(Note: Account id and Password are case sensitive.)

The online renewal system will allow practitioners to update their mailing and practice location addresses and to confirm licensee information maintained by the Department. Practitioners will receive a temporary license upon successful renewal before logging out of the system.

B. U.S. Mail: Mail completed form and fee payable to the Department of Health to the following address:

Department of Health
Division of Medical Quality Assurance
PO Box 6320
Tallahassee, FL 32314-6320

6. Other Information:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 10330 Sequence Number: 480

Profession Code: 1501 20 20

Please make changes to your license information in section 7 on the BACK of this form.

MQA

Active Medical Doctor License # ME 14909 expires January 31, 2004.

DEPARTMENT USE ONLY

The fee of **$454.00** and the renewal notice must be postmarked on or before January 31, 2004. Renewal notices postmarked on or after February 1, 2004 require renewal and delinquent fees of **$839.00**.

This address will be used for all correspondence from the Department of Health.

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

This address will be printed on your license and posted on the Internet.

7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

Go to www.doh-mqaservices.com and renew your license, change your address, and update your profile. Listed below is your user id and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

If you have any changes to the name, mailing address, practice location address, biographic information, license status or military status information associated with your license. Please provide the updated information in the appropriate fields of section 7 on the back of this form.

A. **Online Renewal:** Visit **https://www.doh.state.fl.us/mqaservices** and click on Renew My License to renew your license online. If you are requesting a status change you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2004. To use the online system, you will need the following information:

Account I
Passwo
(Note: Account Id and Password are case sensitive.)

The online renewal system will allow practitioners to update their mailing and practice location addresses and to confirm licensee information maintained by the Department. Practitioners will receive a temporary license upon successful renewal before logging out of the system.

B. **U.S. Mail:** Mail completed form and fee payable to the Department of Health to the following address:

Department of Health
Division of Medical Quality Assurance
PO Box 6320
Tallahassee, FL 32314-6320

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 10330 Sequence Number: 458

Profession Code: 1501 20 20

Please make changes to your license information in section 7 on the BACK of this form.

Active (group 1) Medical Doctor License # ME 14909 expires January 31, 2002.

To avoid a delinquent charge, the fee of **$406.00** and the renewal form must be postmarked or electronically submitted on or before January 31, 2002. Renewal notices/forms postmarked on or after February 1, 2002 require renewal and delinquency fees of **$791.00**.

Current Mailing Address:

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

New Mailing Address:

Licensee's Last Name | First | Middle Initial

Attn:

Street Address:

City: | State: | Zip:

Phone: ( )

Current Practice Location:

7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

New Practice Location:

Attn:

Street Address:

City: | State: | Zip:

Phone: ( )

Description	Department Information	Information is Accurate	Correct Information
Social Security #		◯ Yes ◯ No	
Date of Birth	05/23/40	◯ Yes ◯ No	
Sex	Data Missing	◯ Yes ◯ No	
Race	Not Given	◯ Yes ◯ No	
Race Options: White, Black, Native, Asian, Other, Hispanic & not given			

◯ I am requesting Military Restricted Status. (Military Restricted must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.)

◯ Please remove the Military Restricted Status from my license. (Provide copy of DD214 or letter from Commanding Officer.)

◯ Yes

A. Internet E-Renewal: Web address http://www.doh.state.fl.us/erenewal

E-Renewal allows you to make address changes. E-Renewal does not allow you to renew online by adding or removing a status, such as paying a delinquency fee or changing a license status. Due to high volume, allow sufficient time to renew since **e-Renewal will not be available after midnight Eastern Time (ET) January 31, 2002.** E-Renewal will require the following information:

PIN Number
License Number: ME 14909

B. U.S. Mail:

Mail this completed renewal form and fee payable to the Department of Health to:

P.O. Box 6320
Tallahassee, Florida 32314-6320

File Number: 10330 20 20 Sequence Number: 3138

YOUR NUMBER IS: 436

FLORIDA STATE BOARD OF MEDICAL EXAMINERS
REGISTRATION FOR EXAMINATION

14909

Jan. 19, 1970
(Present date)

Print legibly FULL name (NO INITIALS) and CORRECT mailing address:

Michael Joel Benjamin
249-65 37th Avenue
Little Neck, New York 11363

Birthplace New York City Date 5/23/46

Medical School State University of New York, Downstate Medical Center, College of Medicine

Date of Graduation 6/67

Official Signature Michael Joel Benjamin M.D.

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION
BOARD OF MEDICAL EXAMINERS

APPLICATION FOR CERTIFICATE OF ANNUAL REGISTRATION

(Please Type or Print)

Name MICHAEL J. BENJAMIN

Office Address QUEENS HOSPITAL CENTER, JAMAICA N.Y.

Home Address 39-05 37th AVE LITTLE NECK N.Y. 11363

If in active service give rank, branch of service and service address

License Number 14909 Issued 6th day of MARCH 1970

Medical degree obtained from STATE UNIV. OF N.Y. DOWNSTATE COLLEGE OF MEDICINE in 1962

Sex M Race W Date of Birth 5/23/40 Place of Birth MANHATTAN, N.Y.

Designate Type of Practice

Specialty OBSTETRICS AND GYNECOLOGY Specialty Board, if any

General Practice		Retired	
Active Private Practice		Full Time	
Institutional Practice		Part Time	
Years in Practice			

List other locations where you have practiced NO PRIVATE PRACTICE

3/12/70
Date

Signature [signature]

State of New York

County of Queens

Subscribed and sworn to before me this 12 day of March 19 70

[signature]
NOTARY PUBLIC

RECEIVED
MAR 17 1970
FLA. ST. BD. MED. EXAM.

Notice: Application and $10 fee due on or before MAR 20 1970

MAIL TO: Department of Professional and Occupational Regulation, Board of Medical Examiners, 2717 East Oakland Park Boulevard, Fort Lauderdale, Florida 33306.

List chronologically locations practiced. Give addresses, dates, specify type of practice.

NONE

MILITARY SERVICE: (Attach copy of separation form)

LT. U.S. NAVY RESERVE – BASIC MED
(Branch of service, rank, dates)

FOREIGN GRADUATES: ECFMG Standard Certificate No. _____ issued _____ after passing examination. (Attach photocopy of certificate)

In what states are you licensed? List states and dates licensed in each.

NEW YORK 6/68

If any of the following questions are answered YES give full details on a separate sheet of paper and attach to application. ALL QUESTIONS MUST BE ANSWERED.

Have you ever studied to become, or do you hold a license in any state as a chiropractor, naturopath or osteopath? No

Have you ever failed a written examination for medical licensure given by any state or territorial licensing agency?

Have you ever been denied an application for a license to practice medicine by any state board or other governmental agency of any state or country? No

Have you ever been called before any licensing agency for a hearing on a charge of violation of the medical practice act, unprofessional or unethical conduct? No

Have you ever had a license to practice medicine and surgery revoked, suspended, or other disciplinary action(s) taken in any state, territory, or country? No

Have you ever been convicted of a felony? No A misdemeanor? No

Are you now or have you ever been addicted to the use of ~~narcotics~~ other
Have you ever been charged with addiction

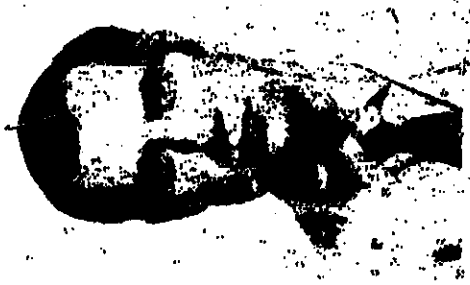
Have you ever made an offer to compromise in connection with the Harrison Narcotic Law? No

Have you ever been addicted to the use of barbiturates or any other medication
Have you ever been charged with addiction?

Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism

Have you ever been adjudged mentally incompetent or been voluntarily or involuntarily committed to a mental institution?

TO BE COMPLETED BY APPLICANT



Date 11/10/69

Age 29

Height 5'-11" Weight 180

Color of Eyes Hazel

Color of Hair Black

Other means of identification Mole

FOR USE OF SECRETARY ONLY

EXAMINATION RECORD

DATE	11-24-70		
Pediatrics			
Surgery			
Obstetrics and Gynecology			
Forensic Medicine and Medical Ethics			
Medicine			
Anesthesia, Urology and Psychiatry			
Eye, Ear, Nose, and Throat and Allergy			
Diagnosis and Therapeutics			
Dermatology, Urology and Venereal Diseases			
Clinical Pathology and Radiology			
AVERAGE			

License Number _____

Date Issued _____

Name as it appears on license.

DOCUMENTS SUBMITTED

Medical Diploma V

Internship Certificate V

Service Separation Form DD 214

Medical Sobriety Recommendation _____

Basic Science Certificate Number _____ Issued _____

ECFMG Certificate _____

Citizenship US

Other _____

RECORD OF FEES

Receipt 6696 Deposited 12-23-69

EXAMINATION NUMBER 436

Jeb Bush
Governor

FLORIDA DEPARTMENT OF
HEALTH

Robert G. Brooks, M.D.
Secretary

July 16, 2001

MICHAEL J BENJAMIN, M.D.
7707 N UNIVERSITY DR SUITE 205
TAMARAC, FL-33321

Dear Dr. BENJAMIN

The information to be published on your practitioner profile is printed below. In carrying out our legislative mandate to publish physician profiles, we want to do everything we can to ensure the information that is published is correct. We are providing this information to you prior to its publication to give you an opportunity to review the data for any changes, corrections, and/or omissions. Under Section 456.042, Florida Statutes, you have thirty (30) days from the date you receive this letter to submit changes to 4052 Bald Cypress Way, Bin # C10, Tallahassee, Florida 32399-3260. If you have no changes, your profile will be published as it appears below on the World Wide Web. Listed below is information that you should review carefully.

First, although the law requires you to report **all** disciplinary action taken by facilities, including facilities outside Florida, the action taken by Florida licensed hospitals and ambulatory surgical centers will not be published on the profile. **Please review and identify any action, which was taken by a hospital or ambulatory surgical center licensed in Florida to ensure this discipline is not included on the published profile.**

Second, the law requires that **all** criminal convictions must be reported to the department pursuant to Section 456.039(1)(a)7, Florida Statutes. If your criminal conviction was expunged or the records were sealed, please send a copy of the court order expunging or sealing the records. If you have any questions or concerns about the criminal convictions to be published on the profile, as they are stated in this letter, please provide them in writing to the department.

☐ My profiling information is correct

☒ My profiling information is incorrect; changes are noted below.

I. **Practitioner Information**

License Number : 14909
Profession : Medical Doctor
License Status : ACTIVE CLEAR
Year Began Practicing : 07/01/1968

Primary Business:

7707 N UNIVERSITY DR SUITE 205
TAMARAC FL 33321

Secondary Locations:

Staff Privileges:

Institution Name	City	State
NORTHWEST MEDICAL CENTER	MARGATE	FLORIDA
CORAL SPRINGS MEDICAL CENTER	CORAL SPRINGS	FLORIDA
UNIVERSITY MEDICAL CENTER	TAMARAC	FLORIDA

Faculty Appointments:

This practitioner has not had the responsibility for graduate medical education within the last 10 years.

This practitioner does not currently hold faculty appointments at any medical/health related institutions of higher learning.

Participates in Medicaid Program:

No

II. Education and Training

Medical School : Dates of Attendance : Graduation Date : Degree Title
1. HEALTH SCI CENTER-BROOKLYN : 08/01/1963 - 05/01/1967 : 05/01/1967 : MD

Other Health Related Degrees:

This practitioner does not hold any additional health related degrees.

III. Professional and Postgraduate Training

This practitioner has completed the following graduate medical education:
Program Name : Program Type : Specialty Area : City : State/Country : Dates Attended

1. LONG ISLAND JEWISH MEDICAL CENTER : INTERNSHIP : TY - TRANSITIONAL YEAR : ..... : NEW YORK : 7/1/1967 - 6/30/1968

2. HOSPITAL CENTER : RESIDENCY : OBG - OBSTETRICS AND GYNECOLOGY : ..... : NEW YORK : 7/1/1969 - 6/30/1971

IV. Specialty

This practitioner holds the following certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed:
Specialty Board : Certification
1. AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY : OBG - OBSTETRICS AND GYNECOLOGY

V. Optional Information

Committees/Memberships

This practitioner has an affiliation with the following committees:
1. QUALITY ASSURANCE COMMITTEE

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has indicated that the following languages other than English are used to communicate with patients, or that a translation service is available for patients, at his/her primary place of practice:
1. FRENCH
2. SPANISH

Other Affiliations

This practitioner has provided the following national, state, local, county, or professional affiliations:
1. AMERICAN COLLEGE OF OBSTETRICS & GYNECOLOGY
2. FLORIDA ~~ACADEMY OF~~ OBSTETRICS & GYNECOLOGY BOARD OF
3. BROWARD COUNTY MEDICAL ASSOCIATION

E-Mail Address

Not Provided

Other State Licensure

This practitioner has not indicated any additional state licensure.

VI. Financial Responsibility

I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance, I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirement through other provisions in s. 458.320 or 459.0085, F. S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

VII. Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

This practitioner has indicated that he/she has NO criminal offenses.

VIII. Final Disciplinary Action (Within last 10 years)

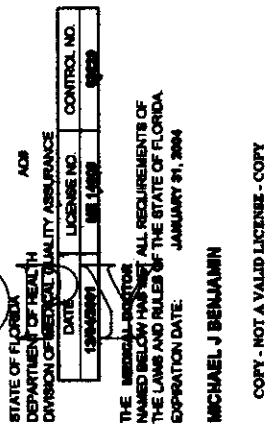
Pursuant to section 456.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/04/2001	ME 14909	63229

THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: JANUARY 31, 2004
MICHAEL J BENJAMIN
7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321



AT LEAST 90 DAYS PRIOR TO THE EXPIRATION DATE SHOWN ON THIS LICENSE, A NOTICE OF RENEWAL WILL BE SENT TO YOUR LAST KNOWN ADDRESS. IF YOU HAVE NOT RECEIVED YOUR NOTICE 60 DAYS PRIOR TO THE EXPIRATION DATE, PLEASE CALL (850) 410-3999.

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: **JANUARY 31, 2004**

YOUR LICENSE NUMBER IS **ME 14909** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER (E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. **A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.**

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF $25.00.

☐ REQUEST DUPLICATE LICENSE _____
SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
MIDDLE

TO: _____
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

_____

_____

_____
CITY STATE ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR
SUITE 205
TAMARAC, FL 33321

7. CHANGES TO CURRENT LICENSE INFORMATION:

◯ **CHANGE OF NAME:**

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title: Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

◯ **CHANGE OF MAILING ADDRESS:**

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

◯ **CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)**

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 2-4 weeks processing time.

REQUIRED:
- ◯ Renewal notice
- ◯ Check or Money order written to Department of Health
- ◯ Financial Responsibility form (check only one item on the FR form)
- ◯ Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

◯ Yes

CHANGE OF LICENSE STATUS:

◯ I wish to change my status from Active to inactive. The fee for an inactive receipt is $415.00. The fee for inactive after January 31, 2006 is $900.00.

CHANGE OF MILITARY STATUS:

◯ I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted is $00.00.

CHANGE OF RETIRED STATUS:

◯ I am requesting retired status. The fee for retired status is $55.00 postmarked on or before January 31, 2006. The fee for retired status on or after February 1, 2006 is $540.00.

DISPENSING:

◯ I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is $100.00 in addition to your renewal fee.

FINANCIAL RESPONSIBILITY

NAME: _____ **LICENSE NUMBER:** _____

Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only one option of the ten provided pursuant to s. 458.320, Florida Statutes.

OPTION I: FINANCIAL RESPONSIBILITY COVERAGE

☐1. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s. 627.367, F.S.

☐2. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s.627.357, F.S.

☐3. I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐4. I have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☒5. I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.0085(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.

OPTION II: FINANCIAL RESPONSIBILITY EXEMPTIONS

☐1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;

☐2. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;

☐3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

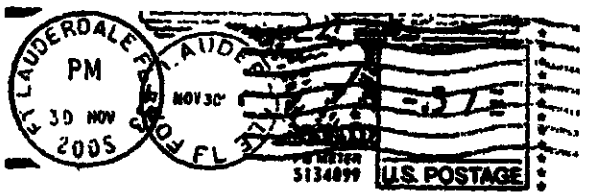
☐4. I do not practice medicine in the State of Florida or;

☐5. I meet all of the following criteria:
(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F.S.; and
(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(f) or 459.0085(5)(f), F. S.

7707 north university dr.• suite 205
tamarac, florida • 33321

MICHAEL J.
BENJAMIN, MD

FACOG



Dept. of Health
Division of Medical Quality Assurance
PO Box 6320
Tallahassee, FL 32314-6320

32314+6320

FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions.

Choose only ONE option of the ten provided pursuant to s.458.320, Florida Statutes.

CATEGORY I - CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

○ 1. I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

○ 2. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

○ 3. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance; I will purchase retroactive coverage for the two years proceeding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

✓ 4. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s. 627.367, F .S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is cancelled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

○ 5. I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.0085(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.

CATEGORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

○ 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;

○ 7. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;

○ 8. I do not practice medicine in the State of Florida;

○ 9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five year period;

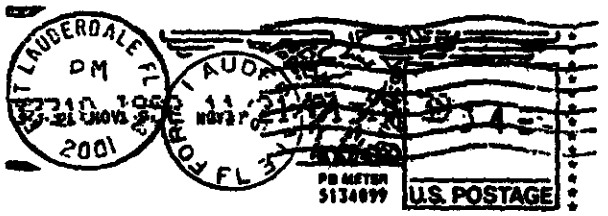
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and

(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(t) or 459.0085(5)(t), F. S.; or

○ 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

MICHAEL BENJAMIN, M.D.
7707 N. UNIVERSITY DR. #205
TAMARAC, FL 33321

FT LAUD FL.



LICENSURE SERVICES
DIVISION OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF HEALTH
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

32314+6320 99

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/11/1999	ME 14000	17571

THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA
EXPIRATION DATE: JANUARY 31, 2002

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR SUITE 205
TAMARAC, FL 33321

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

LICENSE NO.	CONTROL NO.
ME 14000	17571

DATE
12/11/1999

THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA
EXPIRATION DATE: JANUARY 31, 2002

MICHAEL J BENJAMIN

COPY - NOT A VALID LICENSE - COPY

AT LEAST 90 DAYS PRIOR TO THE EXPIRATION DATE SHOWN ON THIS LICENSE, A NOTICE OF RENEWAL WILL BE SENT TO YOUR LAST KNOWN ADDRESS. IF YOU HAVE NOT RECEIVED YOUR NOTICE 60 DAYS PRIOR TO THE EXPIRATION DATE, PLEASE CALL (850) 410-3359.

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: JANUARY 31, 2002

YOUR LICENSE NUMBER IS ME 14000 .PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER (E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. **A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.**

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF $25.00.

☐ REQUEST DUPLICATE LICENSE _____ SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
MIDDLE

TO: _____
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

_____

_____

_____
CITY STATE ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR SUITE 205
TAMARAC, FL 33321

PART B - RENEWAL NOTICE 2000

STATE OF FLORIDA DEPARTMENT OF HEALTH

BOARD OF MEDICINE

IMPORTANT: BY SUBMITTING THE APPROPRIATE RENEWAL FEES TO THE DEPARTMENT, A LICENSEE AFFIRMS COMPLIANCE WITH ALL REQUIREMENTS FOR RENEWAL, INCLUDING CONTINUING EDUCATION CREDITS.

Signature: _____

Please Indicate Mailing Address Change Below

Licensee's Last Name	First	Middle Initial
Street Address		
Street Address		
City	State	Zip

MICHAEL J BENJAMIN
7707 N UNIVERSITY DR SUITE 205
TAMARAC, FL 33321

YOUR **MEDICAL DOCTOR LICENSE**

WILL EXPIRE **JANUARY 31, 2000**

REMIT FEE OF **$355.00**

$705.00 **AFTER EXPIRATION**

Jeb Bush
Governor

FLORIDA DEPARTMENT OF
HEALTH

Robert G. Brooks, M.D.
Secretary

October 18, 1999

Please see attached questionnaire packet — previously mailed out 3/29

MICHAEL J BENJAMIN, M.D.
7707 N UNIVERSITY DR SUITE 205
TAMARAC, FL-33321

Dear Dr. BENJAMIN

We have not received a response as of September 17, 1999, to a letter we sent to you asking you to verify the correctness of your profiling data which is to be published on the World Wide Web. Please review the profile information contained in this letter for any changes, corrections, and/or omissions to insure the information that will be published is correct. Even if you have no changes, check the correct box below and return it to the Department at Post Office Box 6330, Tallahassee, Florida 32314-6330. If you do have changes, please indicate them directly on this letter. If you do not respond to this request within two weeks of the date of this correspondence your profile will be published as it appears in this letter.

☐ My profiling information is correct.

☐ My profiling information is incorrect; changes are noted below.

I. Practitioner Information

License Number : 14909
Profession : Medical Doctor
License Status : ACTIVE CLEAR
Year Began Practicing :

Primary Business:

7707 N UNIVERSITY DR SUITE 205
TAMARAC FL 33321

Secondary Locations:

Staff Privileges:
The practitioner did not provide this mandatory information.

Faculty Appointments:
The practitioner did not provide this mandatory information.

The practitioner did not provide this mandatory information.

Participates in Medicaid Program:

The practitioner did not indicate if he/she participates in the Medicaid program.

II. Education and Training

Medical School : Dates of Attendance : Graduation Date : Degree Title

The parctitioner failed to provide this mandatory information

Other Health Related Degrees:

The practitioner did not provide this mandatory information.

III. Professional and Postgraduate Training

Program Name : Program Type : Specialty Area : City : State/Country : Dates Attended

The practitioner did not provide this mandatory information.

IV. Specialty

The practitioner did not provide this mandatory information.

V. Optional Information

Committees:/Membership

This practitioner has not indicated any committees on which they serve for any health entity with which they are affiliated.

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has not indicated that any languages other than English are used to communicate with patients, or that any translation service is available for patients, at his/her primary place of practice.

Other Affiliations

This practitioner has not provided any national, state, local, county, or professional affiliations.

E-Mail Address

Not Provided

Other State Licensure

This practitioner has not indicated any additional state licensure.

VI. Financial Responsibility

I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S.,from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance, I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirement through other provisions in s. 458.320 or 459.0085, F. S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

VII. Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

The practitioner did not provide this mandatory information.

VIII. Final Disciplinary Action (Within last 10 years)

Pursuant to section 455.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

The practitioner did not provide this mandatory information pertaining to final disciplinary action taken by a specialty board within the previous 10 years.

The practitioner did not provide this mandatory information pertaining to final disciplinary action taken by a licensing agency within the previous 10 years.

The practitioner did not provide this mandatory information pertaining to final disciplinary action taken by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center within the previous 10 years.

The practitioner did not provide this mandatory information pertaining to being asked to or allowed to resign from or had any medical staff privileges &restricted or revoked within the previous 10 years.

IX. Liability Claims Exceeding $5,000.00 (Within last 10 years)

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

There have not been any reported liability actions, which are required to be reported under section 455.697, F.S., within the previous 10 years.

If you wish to make changes to the profile after it has been published, please submit them to 2020 Capital Circle SE, Bin # C10, Tallahassee, Florida 32399-6230.

If you have any questions or comments, call (850) 410-3359 Extension 2009.

Sincerely,

Bureau of Operations

r's Name MICHAEL J BENJAMIN License # ME0014909

FLORIDA DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

FLORIDA DEPARTMENT OF HEALTH
Division of Medical Quality Assurance
P. O. Box 6330
Tallahassee, Florida 32314-6330

CTITIONER DATA

SSIONAL LICENSE NUMBER: ME0014909 (check one) ☑ ME/MD ☐ OS/DO ☐ CH/OC ☐ PO/DPM

(INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):

:NT NAME:

AMIN MICHAEL J

(LAST) (FIRST) (MIDDLE AND MAIDEN NAME, IF APPLICABLE)

:R NAME(S):

(LAST) (FIRST) (MIDDLE)

(LAST) (FIRST) (MIDDLE)

L SECURITY NUMBE. _____ (This will not be published as a part of the profile; also, see instructions on page iii)

IG
:SS: 7707 N UNIVERSITY DR SUITE 205 TAMARAC FL 33321

(STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

RY PRACTICE ADDRESS: (Authority: s.455.565(1)(a)2., F.S.)

N UNIVERSITY DR SUITE 205 TAMARAC FL 33321

CE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

PRACTICE LOCATION(S): (OPTIONAL)

2: (OPTIONAL)

CE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

3: (OPTIONAL)

CE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

HONE: (954) 726-7770 (This will not be published as a part of the profile.)

EGAN PRACTICING MEDICINE: 1968 (Authority: s. 455.565(1)(a)5., F.S.)

. MEDICAL EDUCATION

f all medical schools attended. (Authority: s. 455.565(1)(a)1., F.S.)

SCHOOL/UNIVERSITY	DATES OF ATTENDANCE	DATE OF GRADUATION	TYPE OF DEGREE
HLTH SCI CTR AT BROOKLYN,	63-67	1967	MD

ou completed any graduate medical education? Yes ☐ No ☐

", list in chronological order from date of graduation to the present, all completed graduate medical education. Do not include coursework taken t the continuing education requirement for licensure renewal. (Authority: s. 455.565(1)(a)1., F.S.)

ICAL TRAINING OGRAM NAME	INTERNSHIP / RESIDENCY / FELLOWSHIP / OTHER	SPECIALTY AREA	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY
SLAND JEWISH	INT	FLEXIBLE OR TRANSITIONAL YEAR	NY	7/1/67	6/30/68
HOSP CTR	RES	OBSTETRICS AND GYNECOLOGY	NY	07/01/1969	06/30/1971

Practitioner's Name MICHAEL J BENJAMIN License # ME0014909

III. OTHER HEALTH RELATED DEGREES

Do you currently hold a degree in a health related profession other than the professional degree listed in II. A. above? Yes ☐ No ☒

If "YES", list all medical/professional schools from which a degree in a health related profession other than the professional degree was obtained. (Authority: s. 455.565.(1)(a)1., F.S.)

NAME OF SCHOOL / UNIVERSITY	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY	DEGREE TITLE

IV. FACULTY APPOINTMENTS:

A. Have you had the responsibility for graduate medical education within the last 10 years? (Authority: s. 455.565.(1)(a)6., F.S.) Yes ☐ No ☒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: s. 455.565(1)(a)6., F.S.) Yes ☐ No ☒

If "YES", to question "B" list the title of the current appointment, name(s) and city/state of institution(s).

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			

V. STAFF PRIVILEGES:

Do you currently hold staff privileges in a hospital/medical/health institution? Yes ☒ No ☐

If "YES", list each hospital/medical/health institution at which you currently have staff privileges. (Authority: s. 455.565(1)(a)2., F.S.)

	NAME OF HOSPITAL/MEDICAL/HEALTH INSTITUTION	CITY/STATE
1.	COLUMBIA NORTHWEST	MARGATE, FL
2.	CORAL SPRINGS MC	CORAL SPRINGS, FL
3.	COLUMBIA UNIVERSITY MED C	TAMARAC, FL

VI. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification from any specialty board recognized by the Florida board regulating the profession for which you are licensed? Yes ☒ No ☐ (Authority: s. 455.565(1)(a)4. , F.S.)

If "YES", complete section below.

	SPECIALTY BOARD NAME	CERTIFICATION / SPECIALITY / SUBSPECIALITY	
1.	AMERICAN BOARD OBS/GYN	OB/GYN	11/73
2.	AMERICAN BOARD OB/GY	RECERT	1996
3.			

VII. FINAL DISCIPLINARY ACTION:

A1. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Chiropractic Association, or other similar national organization? (Authority: s. 455.565(1)(a)6., F.S.) Yes ☐ No ☒

If "YES", list name(s) of specialty board(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	SPECIALTY BOARD NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF FINAL DISCIPLINARY ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

A2. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: s. 455.565(1)(a)6., F.S.) Yes ☐ No ☒

If "YES", list name(s) of agency(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N